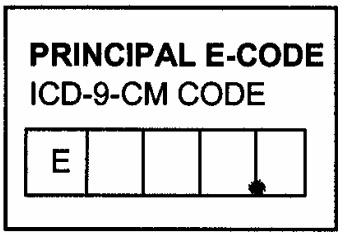
## PRINCIPAL EXTERNAL CAUSE OF INJURY — Section 97260

***The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe external causes of injuries, poisonings, and adverse effects. If the information is available in the medical record, E-codes sufficient to describe the external causes shall be reported on records with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999), or where a code from Chapters 1-16 of the ICD-9-CM (001-799) indicates that an E-code is applicable, except that the reporting of E-codes in the range E870-E879 (misadventures and abnormal reactions) are not required to be reported. An E-code is to be reported on the record for the first episode of care reportable to the Office during which the injury, poisoning, and/or adverse effect was diagnosed and/or treated. If the E-code has been previously reported on a discharge or encounter record to the Office, the E-code should not be reported again on the encounter record. To assure uniform reporting of E-codes, when multiple codes are required to completely classify the cause, the first (principal) E-code shall describe the mechanism that resulted in the most severe injury, poisoning, or adverse effect.***

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for encounters occurring on or after January 1, 2006:




Reporting Requirements

- The external cause of injury, poisoning, or adverse effect shall be coded to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), using the E-codes.
- Reporting medical/surgical misadventure and abnormal reaction codes (categories E870-E879) is optional.

- Duplicate E-codes will not be accepted on the same data record. This is consistent with the guidelines for E-codes in Coding Clinic for ICD-9-CM.
- If more than one drug or substance caused a poisoning or adverse effect, report all E-codes necessary to describe all substances.
- Codes from the Supplementary Classification of External Causes of Injury and Poisoning (E800-E999) must never be reported in the Other Diagnoses code fields. Such codes must only be reported in the Principal or Other External Cause of Injury code fields.

**Principal E-code:**

- Defined as the external cause of injury or poisoning or adverse effects which describes the mechanism that resulted in the most severe injury, poisoning, or adverse effect.
- If sequencing the external cause of the most severe injury as the principal E-code is contradictory to the guidelines given in ICD-9-CM, OSHPD reporting requirements take precedence.

- An E-code is to be included for the first **reported** encounter during which the injury, poisoning, or adverse effect was first diagnosed and/or treated. If a patient was first diagnosed in a doctor's office and then sent to an ED or AS facility, the E-code is to be reported on the ED or AS record. OSHPD does not collect data from physician's offices.

<u>FREESTANDING AMBULATORY CLINICS</u>
If the injury or poisoning or adverse effect was first diagnosed and/or treated during the AS encounter, then report the E-Code on the AS encounter record.

<u>HOSPITALS</u>
If the injury or poisoning or adverse effect was first diagnosed and/or treated during the ED or AS encounter, then report the E-Code on the ED or AS encounter record.

However, if the ED or AS encounter resulted in a same-hospital admission and your hospital combines the ED or AS record with the inpatient record, then the E-code would be reported on the inpatient record.

**Examples:**

Drug reaction during the encounter:
Occasionally a patient may experience a reaction to a drug given at your facility. The reaction (hives, arrhythmia, lethargy, etc.) would be coded as a diagnosis, an E-code for the name of the therapeutic drug would be reported, and another E-code would be reported for the place of occurrence.

Fall from bed:
If the patient fell from a bed at your facility and an injury (e.g. bruise) occurred, the injury would be coded as an Other Diagnosis, and an E-code for the fall from the bed would be reported. Another E-code would be reported for the place of occurrence.

Treated in ED at Same Facility:
If the patient was first treated in the ED of Hospital A and is then admitted as an inpatient to Hospital A, the E code(s) needs to be reported on the inpatient record.

Treated in ED and Transferred:
If the patient was first diagnosed and treated in the ED of Hospital A and then transferred to the Hospital B, the E code(s) needs to be reported only on the ED record of Hospital A. Hospital B does not report the E-code.

Treated at Freestanding ASC and Transferred to Hospital:
If the patient was first treated in a freestanding Ambulatory Surgery facility and then transferred to Hospital A, the E code(s) needs to be reported on the AS record by the freestanding ASC. Hospital A does not report the E-code.

First diagnosed/treated in physician's office:
If a patient with an injury was first seen by his physician and then sent to your AS facility, the E-code would be reported on the AS record because the AS encounter would be the first reported treatment to OSHPD.

Multiple ambulatory surgeries related to the same injury
If the initial AS visit is the first reported treatment of the injury to OSHPD, report the E-code on the AS record. Subsequent AS visits related to the same injury do not require an E-code.